

# MENTAL HOSPITALS AND THE PUBLIC:

## THE NEED FOR CLOSER CO-OPERATION

BEING

A THESIS SUBMITTED FOR THE DEGREE OF DOCTOR  
OF MEDICINE OF THE UNIVERSITY  
OF EDINBURGH

1926

BY

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*October, 1926*



# MENTAL HOSPITALS AND THE PUBLIC.

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## INTRODUCTION.

IN this address I have tried to put in words some small things achieved—or, perhaps it were better put, on the way to being achieved—which are designed to improve the lot of the mentally afflicted person, to soften the attitude of the “group mind” commonly called “the public” towards him, to find for him a place *within* the community during his necessary segregation as we do those sick in body, and not one *outside* of it, or on the fringe of it, estranged from the world as though he were a pariah or outlaw; to improve and facilitate his treatment by bringing in the wake of the psychiatrist the great body of medical science to bear upon his infirmity, both at the earliest possible moment; and finally, on his recovery, to welcome him back to full citizenship, and to find him suitable work so that he may live and thrive—which is the birthright of all men.

These objects have been the ambitions of over a century down to the present day, a task yet to be completed. Much has been done, but during recent years progress has been slow. Changes in the law are required, and, above all, a change in the attitude of the public to mental maladies, to those so afflicted and to the institutions which treat and shelter them, and also a building up of a psychiatry on a broader basis, not separate from, but in close co-operation with the general stream of medical science.

Every successful effort, however small, in these directions is important, in that, when co-ordinated with others, it helps towards the solution of a great and costly social problem which for long ages has faced mankind.

Why then is public opinion so apathetic, prejudiced and unsympathetic in regard to those whom the law labels as “insane,” and why is it so stubborn, so resistant to education in all matters connected with the care and treatment of mental disorders?

First of all, what do we understand by “the group mind”? Obviously the reaction of a group or race of people—always a social group—to environment. It is not quite the same as “public opinion”—which is more discriminative and unstable—but it may be said that the latter has its roots in it.

The “group mind” or “social mind” contains nothing but what is to be found in the “individual mind.” It is really an attitude of mind—that side which develops and functions reciprocally in relationship to the herd and environment.

In studying the group mind of primitive mankind and comparing it with that of men of to-day, one must have regard to mythology—which was an attempt to explain

the phenomena of life without scientifically acquired knowledge, and, therefore, wholly speculative in character. To the outcome of this attempt we now apply the term "superstition." The credulity and mysticism, the fantastic behaviour and beliefs (all as a rule associated with primitive religious thought), having regard to the period at which they occurred should not be regarded as mental aberration any more than are the beliefs and practices of the present time.

Conolly Norman says :

"When any belief tends to reappear in various races from age to age and under conditions of civilization and education, it acquires a special interest because it probably depends on some general trait in the mental organization of our species." "The sense of mystery from which we can never wholly rid ourselves is probably one of the primitive phases of human thought. It is perhaps connected with that great human desire to look beyond the surface of things, and to be unsatisfied with that mere recollection of phenomena which apparently satisfies our fellow creatures who are lower in the animal scale." (*Journ. of Ment. Sci.*, vol. li, 1905, p. 116.)

A. Marie says :

"Mankind will always require a religious faith or ideas of some kind, but there is a regular progression in theological conceptions from primitive savagery onward. When civilized man, by a kind of atavism returns to animism, fetishism, magic or other religious conception prevailing among primitive man, then and then only can religion become a morbid mental state." (*Mysticisms et Folie*, Paris, Giard et Briere, 1907.)

It is feasible to think that the very common endemic and epidemic psychoses of the middle ages <sup>WERE EVIDENCES OF</sup> ~~were~~ regression to primitive beliefs and conduct. Civilization has rendered the occurrence of these more difficult, yet they still break out from time to time as strange forms of religious or sexual excitement in groups of people.

The animism and demonology of ancient Egyptian and Jewish times, also the prevalence of lycanthropy, were perfectly logical, and the belief in them was justifiable, having regard to the state of knowledge in those days. Unusual, strange and inexplicable or extraordinary conduct was thought to be the outcome of "spirit possession" from external sources. Just as the works of the spirit were for good or for evil, so was the spirit viewed as angelic or satanic, and the reaction of the state or group was in accordance therewith. In any case the occurrence was considered to be an act of God or gods. Similarly the lycanthrope attributes his feelings of wickedness and misery to his being possessed by some strange personality—usually a wolf.

The demonology of medieval times must be regarded differently. It was a disease of the social state, a regression of the group mind to the reactions normal to an early age of mankind. At one time the highest level attained by human intelligence, it was now a fall to a lower type of mentalization. It was the symbol of the impoverished mind-play of groups of people belonging to a higher civilization seeking satisfaction and overcoming its feeling of inferiority by taking up again the moral and intellectual supports of a more primitive stage.

This was an age of plague, pestilence and famine and of constant war and civil commotions largely religious in origin and purpose. The belief in witchcraft

and sorcery attained its highest level and the conditions under which the peasantry lived aroused all that was cruel and brutal in human nature. Mental disorder abounded and was often, even commonly, mistaken for witchcraft; an error which persisted for many centuries. Reginald Scott, by a visit about 1580, to Bethlem, became "the first in England to diagnose the element of insanity in the witch and the bewitched" (O'Donoghue). Insanity was generally regarded as a Divine punishment for spiritual wickedness, or as being evidence of the operations of the Devil.

Melancholia, the commonest type of insanity, again took on its primitive form of lycanthropy and masses of degenerate, downtrodden and despairing people became affected at the same moment.

But witchcraft, sorcery and lycanthropy were not all hysteria, paranoia and melancholia. They were also survivals of the primitive religions of Europe, which continued to exist, even flourish, side by side with a Christianity chiefly dogmatic and enjoined for the most part on a people without the accompaniment of an enlightened education. In addition they were often a mask for roguery and criminality, and a cloak for debauchery and cruelty, and there were good reasons, civil apart from religious, which led kings and parliaments to take legislative action against them such as that of the English Parliament in 1573, also that of Rouen in 1643 which condemned such offenders to the tortures of the stake. The pity of it was that bigotry, ignorance and superstition prevented the sorting out of those whose insanity took on these characteristics.

Lecky records that:

"A French judge named Bognet especially to the subject (the assuming of animal forms) burnt multitudes of lycanthropes, wrote a book about them, and drew up a code in which he permitted ordinary witches to be strangled before they were burnt, but excepted lycanthropes—who were burnt alive." (Lecky, *Rationalism*, i, p. 97.)

The term "insanity," or mental aberration, cannot, strictly speaking, be applied to the "group mind." Even the many outbreaks of endemic and epidemic insanity during the middle ages, and occasionally since, were individual mental disorders which spread from person to person—picking out of course those with suitable soil for their manifestations.

The group mind, however, can regress and become active at a more primitive level. The individual insane cannot and will not unite for any one purpose, *i.e.*, a sustained purpose. This fact was probably the reason for the failure of the Crusaders, for among them undoubtedly were included many frenzied, hysterical and paranoid persons.

To come to modern times, the comparative freedom of the group mind from gross atavistic and regressive characteristics is undoubtedly the outcome of the advance of education and civilization. A knowledge of nature, of the cosmic forces of which it is the emblem, and rational ideas as to the why and wherefore of our environment and our relations thereto, spells the decay of superstition and of the practice of incantations, spells, sorcery, witchcraft, etc.

Undoubtedly Buckle, in his *History of Civilization* (Vol. II, p. 148), was right

when he says that the two principal sources of superstition are ignorance and danger—"Ignorance keeping men unacquainted with natural causes and danger making them recur to supernatural ones."

"Human power failing, superhuman power is called in; the mysterious and the invisible are believed to be present; and there grows up among the people those feelings of awe and of helplessness on which all superstition is based and without which no superstition can exist." (Vol. i, p. 88.)

Ignorance and danger give rise to wonder and fear. Now do not wonder and fear, with ignorance and danger behind them, characterize the present-day group mind in regard to mental disorders and those mentally afflicted, and prejudice its attitude to all and everything connected with the insane? Is not this a survival of the medieval attitude in these matters?

These factors are, in my opinion, at the root of that obstinacy, that reluctance to be educated, that apathy and that resentment displayed by the public in lunacy matters.

If McDougall's views on "laughter" are right—that it is an instinctive reaction to circumstances and happenings we either cannot understand or have reason to fear—then the tendency to laughter and witticism so commonly exhibited by people generally when referring to "madness" and the doings of "mad people" is a further support for the view I have put forward that the public attitude to insanity and the insane is in a measure atavistic and regressive and still strongly tainted with medievalism. As to how this can best be met in the interests both of the insane and of the community is the principal matter dealt with in the following pages.

## THE ADDRESS.

I THINK it would be idle to dispute that the public do not view the asylums, or, as they are now commonly named, the public mental hospitals, in the same light as they do the general hospitals, and it appears quite legitimate to ask "Why?" The answer is not difficult to find, though it is not so easily given. Yet it is so germane to my subject that some attempt must be made.

It is to be noted that the origin of both kinds of hospitals is the same. They are children of the same parent, but have grown up so differently that they are now practically strangers to each other.

To understand how this comes about involves some historical research. Now in regard to the care and treatment of those sick in mind, in the Greco-Roman times following the teaching of Hippocrates, who lived about 460 B.C., insanity was recognized as a disease or disorder to be treated by the science and art of medicine at the hands of the physician. The doctor succeeded the priest and magician in the care of the insane. Mechanical restraint was first abolished about 150 A.D., and ultimately the mental institutions such as existed at that period rivalled those even most up-to-date of the present mental hospitals. Solon [630-558 B.C.], one of the seven wise men of Greece, long before this made wise lunacy laws and defined those forms of mental disorder which called for detention.



As you know, all this enlightenment was swept away during the Dark Ages, and became a thing of the past for centuries. Philosophy was replaced by scholasticism. Science became alchemy, astrology, theosophy, necromancy and charlatanry. The insane were again, as they were in the days prior to Greek culture, regarded as afflicted by God and possessed by devils, though not a few were treated as divinely inspired and met with great consideration, even worship and reverence—depending upon the form their mental disorder took. Some were cared for in monastic institutions, but otherwise they became outcasts and less thought of than dogs. More than 30,000 insane were cruelly executed on conviction for witchcraft. This lasted for 1300 years or so, and matters did not improve very much with the Renaissance until about the end of the eighteenth century.

The care of the sick, from very early times, has been closely associated, even identified, with religious organizations and communities and their houses. In ancient Egypt, Assyria and Greece, also in Italy under the Romans, the sick were brought to the temples which were largely supported by the gifts and fees received from patients in return for treatment. The oldest records of such treatment date from about 3,500 B.C. In ancient Greece the sanctuaries founded by the priests of Æsculapius, the God of Healing, were commonly resorted to by the sick and injured, but the Greek physicians, especially those bred at the famous medical school at Cos, were above superstitious practices, and like the present-day general medical practitioners probably treated most of the patients who consulted them at their own homes.

There appears to have been little distinction made in actual practice between those sick in mind and those sick in body until about 100 B.C., when we read of Asclepiades setting up practice in Rome as a psychiatrist, and he has since rightly been regarded as the Father of Psychiatry.

On the rise of Christianity, the care of the sick was continued by the monks and nuns, but probably now in a great measure in conjunction with the Christian physicians, especially those who were famous as specialists in the treatment of particular diseases, for the first Christian hospitals appear to have been for the care of lepers and the insane,\* and came into existence in the days of Constantine the Great during the latter years of the third and the early fourth century.

Somewhat later, in 362, the Emperor Julian founded "houses for the sick"—presumably in Rome—and the Emperor Valens somewhere between 370–380 established a hospital of celebrity in Cæsarea (Palestine). Prior to this, there were hospitals in Rome called "meritoria," similar to the present Chelsea Hospital, for old and decrepit soldiers.

There are two reputed founders of the first hospital or infirmary supported by public subscriptions, namely St. Ephraim (who died in 381), and St. Fabiola, both of whom lived about the same period.

Lecky says :

"A Roman lady, Fabiola, in the fourth century founded at Rome, as an act of penance, the first public hospital, and the charity planted by that woman's hand over-spread the world." (*European Morals*, ii, p. 25.)

\* Many lepers were insane.

I cannot find a definite reference anywhere to the character of this hospital, but from the nature of its origin it would be undoubtedly administered by one of the religious orders, and may, of course, in point of date, be the oldest precursor of the present hospitals, but with all due respect to Lecky as an historian, it would appear to be more true to say that, of Christian times, hospitals for the care of the sick owe their origin principally to the rise of monasticism and the institutions connected therewith, and in this relation the hospital founded in Jerusalem by Pope Gregory the Great at the close of the sixth century, had a more potent influence than any of those I have mentioned.

Probably the majority of references in ancient history anent the treatment of the sick, whether of mind or body, refer to people able to pay for such; as to what happened in this respect to slaves and the poor there is little definite information.

The famous hospital in Jerusalem was originally served by the Benedictine monks from the Mount of Olives and dedicated to St. Mary. In those stormy days it went through many vicissitudes and was refounded by the merchants of Amalphi in 1048, and became the centre of the Knight Hospitallers, being re-dedicated to St. John. Its first Grand Master was Gerard, who died in 1120. The whole foundation consisted of a monastery, a chapel and a hospital. The patients cared for were largely drawn from the pilgrims of whom there was a continuous stream to the Holy Places from the beginning of the Christian era.

I think we may conclude then that hospitals first arose as religious foundations; certainly for centuries afterwards the monks and nuns nursed the sick, and still do in some European countries.\* Even in France it was not until 1880 that the hospitals were secularized, which curiously coincided with the commencement of the period of antiseptic surgery. As regards medieval institutions for the insane, they have existed in Europe since the fourteenth century, their birthplace apparently being in Italy, but it is recorded that one existed in Cairo (called a *morostan*) in the ninth century—a Turkish establishment.†

In England, hospitals, almshouses and Bede houses increased greatly in number on the dissolution of the monasteries, as would be expected from their traditional connection with the care of the sick, and the design of the buildings which arose in consequence of this partook of those they supplanted.

The word "asylum" is a Latin word derived from the Greek *ασυλον*, which signifies a place exempt from plunder. It means a *fixed* place in contra-distinction from its companions "refuge" and "shelter," which words mean *occasional* places. One may say an asylum is a home, and a "refuge" or "shelter" a temporary lodging. All three words mean places of safety. "Asylum" came to be used in the sense of a sanctuary (strictly speaking a "refuge") for criminals, debtors and

\* Every monastery had its *infirmaria* for the sick, weak, aged and blind which was in charge of an *infirmarius*.—See Ducange's Glossary, s.v. *Infirmaria*.

† The first Italian asylum was founded in Rome in 1300, in Spain at Valencia in 1408, and in England (Stone House, London) even earlier than either of these. An asylum at Ghent was founded in 1472 and the colony at Gheel commenced its unique career soon afterwards. Some of the 17th and 18th century asylums had been formerly monasteries. Insane patients were first admitted to the Hotel Dieu, Paris, in 1660, and a large asylum opened its doors at Avignon in 1681. The first American institution for the insane was founded in 1773 at Williamsburg, and in Germany the asylums at Frankfort (1785) and at Bayreuth are ancient institutions.

others, seeking a temporary place of safety, usually a sacred place, from which they could not be dislodged without sacrilege or the breaking of the civil law. It became the privilege of the Church to afford asylum from the time of Constantine the Great which was regulated by law in 392. In the middle ages hospitals likewise acquired this privilege.

For a long time now the word "asylum" has been used to denote an institution for receiving, maintaining and ameliorating the condition of people suffering from physical or mental defects and maladies.

Its specific use as the designation of an institution for the insane seems to date from the early part of the seventeenth century, and became common during the following century. It cannot by the greatest stretch of imagination be rightly applied to a place of detention. From 1845 onwards it has had a legal definition. In the preface to the first edition of Archbold's *Lunacy Law* occurs the following paragraphs :

"Public asylums are provided, private establishments are licensed, and hospitals registered, etc." "Every precaution is taken that none but persons who are really insane, and proper objects for detention under care and treatment . . ."

It is clear then that "asylum" should never have been used to designate an institution for those mentally afflicted, because it implies (a) a place which people *seek* as a fixed "home," and (b) a place which shelters and cares for those who need shelter and care, but does not detain them.

The same objection might be raised in this connection to the word "hospital," but the latter is a better word in that it essentially denotes a *temporary* resting place, and as regards meaning its companion words are "Inn" and "Hotel."

It is interesting to note that psychiatry as far back as July 27, 1841 was beginning to feel the incubus of the terms "lunatic" and "lunatic asylum" imposed by the law, for at the first meeting of the Medico-Psychological Association held on that day the following resolution was passed :

"That by the members of this Association the terms 'lunatic' and 'lunatic asylum' be abandoned except for legal purposes and that the terms 'insane person' and 'hospital for the insane' be substituted."

The term "hospital," applied originally to travellers' rest houses, has now come to mean an institution for the care of the sick or injured, or of such as require medical or surgical treatment, and, as we have seen, came about through the latter being cared for in the hospital of the Knight Hospitallers in Jerusalem. Others were established in Europe soon afterwards, at the initiative of the religious military orders and religious houses, chiefly to combat plague and other infectious diseases from the East. No doubt many of those treated in these institutions were mental cases whose sickness in mind was associated with obvious bodily disease. Later, as we have seen, most of the insane were not so fortunate for several centuries.

Two of the oldest separate hospitals in this country were those founded by Archbishop Lanfranc at Canterbury in 1080-84, one for lepers, the other (The Hospital of St. John) for general diseases and infirmities.

I need not go in detail into the origin of earlier English general hospitals such as



St. Bartholomew's, St. Thomas's, in London; their names are significant either directly or indirectly as to how they began and from whence came their original endowments. One mental hospital arose in the same way, namely Bethlem, as far back as 1247 A.D., and admitted its first mental patients from Stone House in 1377, and is now about to take on a fourth lease of life on a better site.\*

St. Luke's Hospital was founded in 1751 as a second Bethlem, and it is noticeable that the hospital buildings of Bethlem at Moorfields and St. Luke's both embodied in their structure long galleries and single rooms, like most of our older mental institutions, confirming the tradition that the monastery, with its corridors and cells, was considered the proper model for a mental hospital.

Now the circular appealing for funds to establish St. Luke's Hospital for the Insane issued by the Founders in 1750, "who were certainly wise and good men in their generation," contained this remarkable paragraph:

"Although the only end proposed was to establish a charity for poor lunatics, in such manner that hereafter all persons who shall be found proper objects may, for the sake of the public as well as themselves, be admitted without delay, and (should our success answer our expectations) without expense also. Yet some advantages of a very interesting nature to the good of all mankind certainly will arise in consequence of it; for more gentlemen of the faculty making this branch of physic their particular care and study, it may from thence reasonably be expected that the cure of this dreadful disease will hereafter be rendered more certain and expeditious, as well as less expensive. And from the many improvements already made in other arts and sciences, as well as in the several parts of physic, the same may with reason be concluded in the present instance." [Vide *Journ. of Ment. Sci.*, January, 1856, p. 220.]

It is obvious that St. Luke's was expected to function also as a school for the teaching of psychiatry. Pinel, the great French reformer of the treatment of the insane in France, was only five years old at this time, yet these simple citizens had visions of a better psychiatric service in the future, and St. Luke's, with Bethlem, did indeed become precursors of the psychiatric hospital ideal of Greisinger, of Hayes Newington, of Brudenell-Carter, and of Maudsley. So this period is a convenient one to commence from in our consideration of the attitude of the public to the insane and to mental institutions.

In the year 1750 there were in existence in London the following voluntary general hospitals:

St. Bartholomew's, 1123 (refounded 1547); St. Thomas's, 1200 (refounded 1553); Westminster, 1719; Guy's, 1721; St. George's, 1733; London, 1740; Middlesex, 1745; together with the British Lying-In, 1749; the City of London Maternity Hospital, 1750; Queen Charlotte's, 1752; the General Lying-In opening its doors three years later.

In the English provinces there were voluntary general hospitals at Bath (1737), Bristol (1735), Exeter (1741), Liverpool (1745), Northampton (1743), Rochester (1078), Shrewsbury (1747), Winchester (1736), Worcester (1746), York (1740).

\* The five Royal Hospitals in London, all enriched by monastic and church property following the Reformation, were St. Bartholomew's, St. Thomas's, Bethlem, Bridewell and Christ's. The last named became a famous school. Bridewell Hospital and Prison, founded in 1553, was destroyed in the great fire of 1666.

During the following century voluntary general hospitals sprang up like mushrooms, also many special hospitals; and both, especially the latter, have continued to multiply with the increasing necessities of a growing population.

People of all classes have continued to pour out their money and treasures to provide for the care and treatment of the poor suffering from physical diseases and disorders.

Now let us look at the case of the sick in mind. I am not at the moment concerned with those well blessed with this world's goods and chattels. Their interests when mentally afflicted were always protected by the State, though, like the insane poor, they suffered in the private mental institutions—now called licensed houses—from the barbarous practices then thought to be right in the medical treatment of the insane. One reads of the old Metropolitan Commissioners in Lunacy discussing the comparative efficiency of chains and handcuffs, iron girdles, collars and strait-waistcoats. They once reported that handcuffs and chains were preferable to strait-waistcoats as less heating. From voluntary sources beds existed at Bethlem (Moorfields) (1377), Guy's Hospital (1744 to 1859), Bethel House, Norwich (1713), and a few at some of the provincial voluntary general hospitals and infirmaries. Before the end of the century there came into existence St. Luke's Hospital (1751), Bootham Park (1777), Liverpool Asylum (1792), and the Retreat (1792). From 1800 onwards to this day there has been founded only nine other registered hospitals for the insane—a total accommodation of less than 2500 beds from this source, and the beds in the voluntary general hospitals and infirmaries became things of the past until recently.\*

Thus, in 1750 nearly the whole of the indigent mentally afflicted were either at large, living by such few wits as they possessed from birth or were left to them after some acute attack, and subjected to the jeers, jibes, rough humour and sport—even the violence and brutality—of the public; or, if considered dangerous, they were confined by a magistrate's order, under an Act dated 1744, in jails, houses of correction, poor-houses and houses of industry, where they were in an infinitely worse plight than when at large. They were placed there not so much for their own welfare and protection as for the safety of the public.

I do not propose to harrow your feelings with a description of the housing and general treatment of these poor and mentally afflicted brothers and sisters, or of the horrors of the then recognized medical treatment by restraint and repression, which had existed since mediæval times. In some of these institutions there were separate apartments for the insane, but as often as not vice, crime, misfortune, mental infirmity and chronic diseases of the most revolting kind were all sequestered together and treated alike. The insane were, as a rule, chained or tied with ropes, unutterably filthy, in filthy surroundings, with beds of straw rarely renewed, or with no beds at all save the cold stone floors. Often they were without any covering either by day or night. They were starved, not infrequently flogged, and sometimes

\* In Scotland, public and private response was much greater, and the Royal or Chartered Asylums, seven in number and one without a Charter, date from 1781 onwards until the Scottish Lunacy Act of 1857 led to district pauper lunatic asylums being established. The Royal Hospital at Morningside opened in 1813, the result of nearly 40 years' agitation by Dr. Andrew Duncan, the Scottish "Tuke."

killed. Of course the death-rate was enormous. The conditions at Bethlem and Bethel House and other hospitals were but little better, and the medical treatment in the private houses or asylums was equally brutal, though housing conditions were apparently not so appalling. The general public were callous to all this, but in this connection it must be remembered that it was difficult in those days to arouse the public conscience. Travelling was expensive and dangerous and the means limited. The Press had not developed to any extent. Still, the conditions generally must have been well known—certainly to the local authorities.

John Howard [1726–1790] was probably the first to set the ball rolling towards reform. In the famous report on his visits to the prisons throughout England, which he laid before Parliament in 1777, he drew attention to the shocking conditions he found in regard to the confinement there of idiots, imbeciles and lunatics.

We celebrate the bicentenary of his birth this year. The debt of gratitude the nation owes to him is incalculable.

The insanity of King George III and his treatment also drew public attention to the subject of lunacy. Parliament had already inquired into the matter and the Act of 1744 had resulted, which was but a poor attempt to right the great wrong that existed.

Theobald says about the private asylums :

“When once a person had been placed in a private asylum it was not difficult for the keeper to prevent him from having any access to the outer world, and a person who had disappeared into a lunatic asylum was very often not heard of again. . . . Patients were wrongfully detained ; they were treated with great cruelty ; they were often unsufficiently clothed and underfed ; they were subjected to the terrors of solitary confinement and to methods of mechanical restraint which rivalled in cruelty the torture chambers of the Middle Ages.” (*The Law Relating to Lunacy*, p. 65.)

Parliament, in 1774, at last became convinced that something must be done, and that year saw the commencement of a series of Lunacy Acts culminating in the famous Act of 1890.

However, it was in consequence of the agitation of a few that the Act of 1808 was passed, which Act empowered the County and Borough magistrates to establish public asylums for the poor.

Efforts to make this provision on the lines of the voluntary hospitals were ineffectual to meet the growing need. The tendency showed by voluntary general hospitals and infirmaries in early days to house the insane, limited to a few beds for chronic cases, received little or no encouragement from the public. It was opposed to the lunacy policy of the times and discouraged by the Lunacy Commissioners on legal and treatment grounds. Private benevolence largely stood aside and so the tax-gatherer came to step into the breach, and the fate of psychiatry was sealed for many years.\* The ignorance and superstition of the public in regard to the insane were too great. The Act of 1808 was not popular, as is shown by the fact that no action was taken until 1812, when Nottingham County Borough

\* See Lord Shaftesbury's evidence on March 14, 1859, before a Select Committee of the House of Commons.

Asylum was opened at Sneinton (now disused). It had, however, been projected since 1789 in connection with the Nottingham General Hospital and £6,000 collected, but in 1809, under the Act of 1808, the County and Borough Authorities came to the rescue and united with the subscribers. Only 10 county asylums had been established by 1818, and 20 by 1850. By the Lunacy Act of 1845, this provision was made obligatory.

*À propos* of the medical treatment of the insane in those days, I cannot do better here than quote from a speech I made at a dinner held in honour of the founders of the Royal Medico-Psychological Association on November 17, 1925 :

“ As regards general medicine, the old-time notion which had prevailed throughout the Dark Ages that disease was a something foreign which had entered the body and had, at all costs, to be driven out, still influenced treatment to a large extent—hence blood-lettings, sweatings, purgings, blisterings and other reducing measures which were largely practised, though to a diminishing extent. But the idea was gaining ground that much disease could be viewed as normal body-processes endeavouring to carry on under adverse and unnatural circumstances, that these normal processes needed to be strengthened and built up and that under the watchful care of the physician the body would cure itself.

“ The treatment of the mentally afflicted, however, remained entirely unenlightened, and the ideas of the Dark Ages were still in the ascendant in all their terrible malignity. The ‘ devil possession ’ notion guided all care and treatment. There was restraint and repression of every kind, some of it most ingeniously devised ; blistering, purging, starvation, flogging, shock-baths, bleeding, and cruelties too horrible to mention were recognized as legitimate forms of medical treatment. That anybody in charge of the insane in those days could bend the knee and bare the head and offer up a prayer is inconceivable to us nowadays ; yet the doctors, at any rate, were good-living and respectable men, many of them held in high esteem. So ingrained was the heritage of religious bigotry that both justice and humanity were dethroned.

“ But the period 1798 to 1835 saw the beginning of the salvage of an ancient and honourable branch of medicine from the dominance of superstition and cruelty, and psychiatry began once more to take a place among the medical sciences.”

Now the resurrection of the science and art of psychiatry and the humanitarian care and treatment of the insane was a movement which seemed to spring up about the same time at numerous points in Europe towards the end of the eighteenth and the beginning of the nineteenth centuries, and the birth of modern psychiatry dates from the work of Daquin, Pinel and Esquirol in France ; Fricke, Langerman, Reil and others in Germany ; Chiarrugi in Italy ; Guislaam in Belgium ; Evert in Holland ; Rush in America ; Duncan in Scotland ; and Tuke, Gardner Hill and Connolly in England.

I cannot pause to narrate the fine work of Tuke at the Retreat, or speak of that humanitarian movement in this country which owed so much to Lord Ashley (afterward the Earl of Shaftesbury), for its success : sufficient to say that from 1812 onwards county asylums began to dot the country-side. Gardner Hill and Charlesworth at Lincoln in 1335 commenced the non-restraint treatment, which was taken up and perfected by Connolly at Hanwell, whose influence and writings led, in a few years’ time, to its general adoption throughout the public and private mental hospitals ; though it lingered for some years longer in the workhouses, as is shown

by the dreadful conditions revealed in the supplement to the 12th Report of the Commissioners in Lunacy dated April 13, 1859.

Referring to the pauper lunatics entrusted with the custody of their more weak-minded fellow prisoners, the report says :

“ To such individuals, strait-waistcoats, straps, shackles, and other means of restraining the person are not unfrequently intrusted; and they are, moreover, possessed of the power of thwarting and punishing at all times, for any acts of annoyance or irregular conduct, which, although arising from disease, are nevertheless often sufficient to provoke punishment from an impatient and irresponsible nurse.”

The *Journal of Mental Science* of July, 1859, in reviewing this report remarks :

“ Here we must conclude our notice of this most important, and, we may add, painfully interesting report; for it is painful to find our insane poor placed under circumstances, not only discreditable to us as a Christian, but also as a civilized and humane people; and society owes a debt of gratitude to the Commissioners in Lunacy for the complete manner in which they have pursued their investigation into the condition of establishments only indirectly and secondarily subjected to their supervision. The ill-results of their deficiency of power in dealing with lunatics in workhouses, and in controlling the provisions made for them, appear in almost every page of the report, and we trust that this defect will no longer obtain, but that Parliament will lodge in their hands the power to supervise and control the lunatic wards of workhouses to an equal extent, as it has empowered them to act in county and other asylums for the insane, which have derived so great an advantage from the existence and the activity of the Commission.”

Now the great progress general medicine has made has been intimately bound up with the evolution and expansion of our voluntary hospital system and the founding and growth of the nursing profession.

Psychiatry has undoubtedly suffered from its enforced detachment from this movement, and its story and the attitude of the public to the insane would have been vastly different had it been decreed otherwise, and the present burden of chronic insanity in all probability would have been much lighter.

It is nothing short of a calamity that these two children of the ancient hospitallers, the general hospital and the mental hospital, should not have grown up as comrades, and that the sociological factors which led to the founding of voluntary hospitals for physical diseases should not have included an adequate number for the treatment of occurring mental diseases.

It is also to be regretted that it was not found possible to encourage the tendency general hospitals and infirmaries one time had to make some provision for mental cases. Had this been fostered by wise enactments to secure humane care and treatment it might have led to an “open door” instead of the “closed door” policy to mental disorders being adopted by these institutions which still very generally holds good.

This estrangement has never been so marked in Scotland as in England. To-day it scarcely, if at all, exists in the former country, which fact is largely due to the thoroughly systematic teaching of psychiatry at the medical schools and general hospitals in association with the mental hospitals which are attached to them for this purpose.



The isolation of psychiatry from the main stream of medicine would in a large measure have been prevented, and the study and treatment of mental disorders would have had that mutual collaboration and co-operation within the fold of general medicine which has been so beneficial to all its other branches.

The country willingly pays about £8,000,000 a year for the upkeep of the general hospitals with their 46,000 beds, and had it adopted a voluntary system of mental hospitals a more advanced psychiatry might have unloaded by several millions the present cost (£7,000,000 for about 105,000 mental hospital beds) by having a considerably less number of chronic insane to accommodate.

Now to come to the present-day attitude of the public to the mental hospitals.

This is not a problem which stands alone: it is bound up with that of the relationship of psychiatry to the law, of psychiatry to general medicine, and of the public mental hospitals to the general hospitals. All these factors have adversely affected the progress of psychiatry. Not only so, but every one of the foregoing factors have added their quota to that continued lack of active interest of the public generally in those mentally afflicted and in the welfare and work of our public mental hospitals. And, furthermore, what is a matter of still greater regret is that public opinion has never really emancipated itself from the thralldom of medieval thought in its ideas of insanity.

This is very evident from the attitude which the public take up in regard to those discharged from mental hospitals and the disinclination to employ them.

The medical officers of mental hospitals are also keenly aware of it from the distress the friends of patients show on their first visit. It is often difficult, if not impossible, to make them believe that there is no disgrace in being mentally afflicted, that mental disorder should be looked upon in the same light as physical disorder and that the ideals and functions of mental hospitals and general hospitals are fundamentally the same. They are therefore often difficult to satisfy, being suspicious, over-anxious, querulous and imbued with wrong notions—not only as to the nature of insanity, but also as to the nature of the work of the hospital. Most of them soon learn, however, that things are not so bad as they had thought; indeed, as a rule, the relationship between the hospital staff and the patients' friends becomes most cordial and, but for the publicity which would be given to the private affairs of the family, there would be no lack of individual expressions of appreciation of the care and treatment patients in public mental hospitals receive.

However, in most of these respects, the future gives promise of shaping itself for the better.

Psychiatry and general medicine are undoubtedly drawing nearer each other, and the proposals to establish mental clinics at the general hospitals and to affiliate mental hospitals with the general hospitals will do much to cement those ties which are gradually linking up psychiatry and general medicine.

The movement for mental hospital nurses to acquire general hospital training, and to a less extent *vice versa*, is an active one and is extending.

The loosening of the legal restrictions as to the care and treatment of mental disorder in its early or acute stages is now being called for with greater unanimity,

and, of all points put to the Royal Commission, the proposal to allow the public mental hospitals to admit voluntary cases has secured a more general support than any other. I am one of those who believe that this concession will prove a powerful factor for good in regard to both medical administration and treatment in these institutions. The best is never absolute and can always be improved upon, and mental hospitals avoided by voluntary patients will need to look into their nursing and medical administration a little more closely. For the first time there will be an element of competition, the absence of which is one of the drawbacks to progress in all institutions depending solely upon the State or local authorities for their maintenance.

The final object which remains to be dealt with is to bring the public generally to look upon those sick in mind and the work of the public mental hospitals in the same light and with the same active sympathy and interest as they do those sick in body and the work of the voluntary general hospitals; and this is really the key-note of my address to-day.

The problem presents difficulties in two directions :

(1) Public mental hygiene education requires much thought and care, for nothing is more likely to sap the stamina and courage of a nation than an over-consciousness of nervous and mental processes on the part of its citizens, and on the whole it is perhaps better that a community should not know that it has any mental processes or nerves at all than to become hypochondriacal and neurasthenical, and

(2) having arrived at the range of facts it would be advantageous for the public to know, how can these facts best be disseminated ?

Regarding (1), no body of knowledge is more difficult of comprehension than psychology unless it is that commonly known as metaphysics, which includes cosmology and ontology. It is not given to everybody to be capable of achieving an insight into this subject, hence it tends to be confused with ethics, morality and religion about which the public are very responsive, and prone at all times to take up unhealthy and bizarre notions. Under these circumstances I think it much safer and wiser to teach the simple facts of mind and mental disorders in close relationship with physiology, and preach mental disorders as the manifestation of disordered brain and other physical functions.

As to (2), a suggestion as to the education of children in these matters is made later, but here I may say that as Secretary of the National Council for Mental Hygiene, I contemplated broadcasting, in the form of a pamphlet, simple facts regarding the mind, mental disorder and mental hospitals. This, however, would be an operation of some magnitude and considerable expense, and was judged to be impossible. It therefore occurred to me that such knowledge was most urgently needed on the part of those with relatives or friends mentally afflicted, especially if under care in a public mental hospital. I then fell back on the idea that such a pamphlet should be sent to the relatives and friends of every patient admitted to any such institution throughout the land. I am glad to say that one very large local authority in fact has substantially incorporated my remarks, which follow, regarding the mind in health and disease and the nature and functions of mental hospitals in an intro-

duction to the *Mental Hospital Visiting Rules*. Such information does much to relieve the anxiety of relatives and friends and corrects their frequently mistaken notions and tends to establish from the first a good understanding between the friends of patients and the nursing and medical staff of the mental hospital. I am hoping that the example thus set will be followed by every local authority.

First of all, then, what are the facts the public in general should be brought to appreciate regarding mental disorders? These may be stated as follows:

In the first place it may be remarked that what is known as the "mind" depends upon the activity of a healthy nervous system and upon the harmonious working of all the bodily functions.

It follows that there is a wide range of causes for mental unhealthiness, many of which are comparable to the causes which are responsible for bodily diseases. So the problem presented by the occurrence of mental disease is essentially a medical one.

But when a person mentally afflicted is unfit to be at large and incapable of attending to his own affairs, the problem has also a social and a legal aspect.

Now there are many degrees of mental unhealthiness short of actual mental breakdown. Feelings of being "run down," "fed-up," "needing a change," are but expressions of mental fatigue or anxiety and are as common as colds in the head. Cases of "nervous exhaustion" or "nervous debility" or "nervous breakdown" are less common but still everyday occurrences and have good chances of recovery without institutional care if treated early. Such cases usually are fully conscious of their illness and naturally seek medical advice and treatment.

Grave forms of mental breakdown commonly present a different picture and are not so readily understood. The onset may be sudden or slow. As a rule the patient declares himself to be quite well and, indeed, often looks the picture of health and resents the suggestion of medical advice. His mental infirmity has to be judged outwardly by his conduct in regard to his surroundings and ordinary mode of life.

The important point to be remembered is that both the slighter and the severer forms of mental unhealthiness—the case of "nervous exhaustion" and the case of "certifiable insanity"—are fundamentally the same, and should be regarded as such: also that superstitious views regarding insanity or mental disorders belong to the past, and that the adoption of a superior, scornful, derisive or facetious attitude to an insane person, or one who has been mentally unsound, is both unkind and foolish, prevents the early treatment and recovery of such cases and favours the accumulation of incurable insanity, which is a burden to the community.

It is the universal experience in mental hospitals that the cases which mostly recover are those of short duration prior to admission, and that the longer the patient who is ultimately admitted is kept at home the fewer the prospects of recovery. At the same time there is undoubtedly a "stigma" attached to an ex-mental hospital patient.

By avoiding mental hospital treatment the case may become a hopeless one; by adopting it a life may be partially wrecked, because of this "stigma" which seems ingrained in the minds of the people. The rising generation need not, however, be brought up in ignorance of fundamentals regarding insanity. The educational

code of our national schools should decree a course on both mental and physical hygiene for senior pupils. This would do much to remove the "stigma" of "lunacy," which handicaps all the mentally afflicted both in the early stages of their complaint and after recovery.

Now as to the public and the mental hospitals. The public should be brought to understand the following facts :

That mental hospitals are merely special hospitals for the treatment of the severer forms of mental disorder which cannot be adequately treated at home.

Insanity is not only associated with faulty brain function, but it involves sickness throughout the whole organism in a greater or lesser degree. A mental hospital has therefore to undertake the functions of every kind of hospital. It is at once a place of safety and refuge, a maternity home, a hospital for special diseases, a general hospital, and a psychiatric clinic.

That in addition to mental nursing the nursing staff of a mental hospital are trained to nurse all kinds of physical diseases. The treatment of the patients is in the hands of an expert medical staff who have the assistance of a dentist and a chemist, and when necessary of specialists in all branches of medicine and surgery. The head of the hospital is a medical man who co-ordinates the work of the whole staff with a view to making the patients' lives as happy and as home-like as possible, and securing for them the best medical attention and nursing obtainable. The greatest possible liberty in the gardens and grounds is allowed the patients ; there is no mechanical restraint, and suitable cases go out for walks and shopping in the surrounding country and villages. Ministers of religion look after the spiritual welfare of the patients.

That although it is one of the functions of a mental hospital to detain patients in their own interests and for the security of the public, its principal function is the treatment of patients so that they may be discharged recovered, or with their mental infirmity so far relieved as to render possible their restoration to friends and home surroundings.

That the power to discharge patients (wholly or partly) chargeable to the rates is vested in the Committee of Management of the Hospital. In the case of patients of the private class, this power is shared with the relatives and friends. Also that the members of the committee are often well known and highly esteemed in the district in which the patient lives when at home.

That the work of the "Mental After-Care Association" (and allied societies) is worthy of the support of the public. This voluntary association undertakes the task of re-starting in life poor persons discharged recovered from mental hospitals, also their supervision when out "on trial" prior to final discharge.

And lastly, but not least, that there is also attached to not a few mental hospitals a Lady Visitor who is in many directions a source of great comfort to the patients, especially those recently admitted. She acts as a connecting link between them and their homes, thereby relieving their anxiety and materially assisting towards their happiness and contentment. In this work she is assisted by social workers.

It is to be regretted that psychiatry does not seem to obtain a good Press. I



do not blame the Press, for after all, one of its principal functions is to voice public opinion and, if the latter be prejudiced, uninformed and commonly apathetic in regard to the welfare of the insane and the work of the public mental hospitals, the attitude of the Press generally can hardly be expected to be otherwise. Some, however, of the great daily newspapers are very fair-minded on this subject. But we suffer from the occasional enterprising journalist who has succumbed to the wiles and plausibility of the half-cured lunatic (often a quasi-paranoic) or, worse still, the really vicious high-grade imbecile with a bone to pick, and who has been discharged from a mental hospital. This pandering to the taste for sensationalism cannot fail to have a very prejudicial effect on the practice of psychological medicine, especially as the other side of the picture rarely obtains the same publicity.

Wild stories, with often only a semblance of truth, sometimes find easy credence and, after being written up into sensational articles, are served to the public as established facts, and the closest inquiry demanded. As a rule the name of the institution or doctor is not mentioned. Neither the Board of Control nor the public institution concerned if named can prosecute, not being industries or establishments run for profit. Public inquiries cost time and money, and as regards the doctor, he would probably find great difficulty in initiating legal proceedings. The psychiatrist is constrained to ask, How long is progress in the enlightened treatment of the insane to be hindered and discouraged (for that is the effect) by such irresponsible journalism? It is not that those whose lot it is to undertake the care of the mentally afflicted claim immunity from criticism, but it is only fair to any public service that some inquiries should be addressed to those concerned before inviting public condemnation; some regard should also be paid to the relatives and friends of patients before creating an atmosphere of anxiety and uneasiness.

Dr. R. H. Cole, in his Presidential Address to the Section of Psychiatry, Royal Society of Medicine (November 10, 1925) has something to say about this:

If "the relationship of psychiatry to law reflects a lack of progress, what can be said of the public attitude to our branch of medicine? It is disappointing, to use a mild expression, to find a recent leader in a highly respectable daily journal referring to the devoted men who have laboured for psychiatry in the past as 'keepers of mad-houses.' Such an expression, applied to the memories of a Maudsley or a Mercier, can only reflect a deplorable ignorance on the part of educated public opinion.

"A novel has lately appeared, written by a distinguished author, and dealing with the adventures of an elderly psychotic who is finally admitted to a mental hospital. The terms in which the descriptions are written are disquieting and reminiscent of the past. Prejudice and unfamiliarity with existing conditions indicate the want of sympathy and understanding shown by the general public to the psychiatric physician and his work."

Let me quote here some paragraphs from my *Social Workers and the Insane*, slightly emended. In reply to the question, "Are kindness, sympathy, pity, charity, love wasted on the insane?" I say—

"Truly a mental hospital is a house of comedy and tragedy. Reasoning and argument have no practical value therein. Only sympathy, kindness and true friendliness are of any avail. The mind-commotion in insanity is deep-seated. A man



may think and feel as he likes—his thoughts and feelings being his own ; but when the foundations of his mind (those inherited and acquired impulses, strivings, motives, desires, emotional reactions and natural intelligence—common sense—which are the basis of human character) become disorganized and his conduct is involved, the social machine has something to say, hence the restrictions the community places on his liberty.

“The power of love and kindness to control the conduct of others is unlimited. How are the insane kept in a mental hospital ? If they decided to go home, home they would go. Our light hospital buildings and the proportionately few nurses would not keep them a moment ; yet escapes from asylums are perhaps fewer than from prisons.

“Bars to windows, physical restraint, etc., are unknown nowadays in mental hospitals. The chains are there, however, although not forged from iron or steel. They are much stronger and more effective, being links of kindness and persuasion, the artificers being the doctor and the nurse.

“So it is not that the ground is barren for the exercise of these virtues. On the contrary, they are the only crops that flourish.”

It will be long before the general public will be brought to believe this. I for one at least do not despair that they will in time, but it behoves the mental hospitals to take these ideals more and more to heart and thus make them more and more potent for good. Now, if these notions were to prevail generally among the community, most of the troubles regarding the treatment of mental diseases would disappear. There is no doubt in my mind that the work of mental hospitals suffers because of the continuance of public ignorance as to what insanity really is and the prejudiced attitude adopted to the insane and the ex-mental hospital patient.

The mental hospitals lack public sympathy and support. They need the public to be with them and not apathetic or against them. They work in too much isolation and secrecy and are thus easy victims to misrepresentation and abuse. There should be more opportunities for public co-operation and for public criticism and appreciation of the work of the mental hospitals.

It must be remembered that mental hospitals are of necessity bound by law and rule and, despite the goodwill of the local authorities, they are not as free to experiment, expand, evolve and progress with the general advancement of medicine as general hospitals on a voluntary basis, which have more liberty and less restrictions in the matter of expenditure.

Furthermore public mental hospitals, in addition to their primary function of curing or alleviating mental disorders, are called upon to carry out an essential duty to the community by acting as the guardians of the insane who are incurable. The general hospitals, speaking figuratively, put their incurables on the door-step for removal elsewhere and wash their hands of them.

There is a tendency nowadays to forget, in the enthusiasm for the hospital treatment of early and curable cases, that one wholesome function of the Lunacy and Mental Deficiency Acts is the segregation from the public of those who, by reason of mental disorder or defect, impair the social machine by their inefficiency as citizens, and that the more thoroughly this is done the better for the home and for the nation.

We thus reduce the intensity of many other costly social problems. In the majority of cases the private care of the chronic lunatic is but a poor substitute for

institution care and, unless there is exceptionally suitable environment, the proper place for such a person is undoubtedly a mental institution.

Nevertheless mental hospitals should, as far as practicable, be thrown open in the same spirit as are the general hospitals, and the cleansing and stimulating influence of a correctly informed public opinion brought constantly to bear upon mental hospital care and treatment. Mental hospitals, like general hospitals, should be part and parcel of the everyday life of the community and not excrescences hidden away and remote from the public eye.

How this could best be brought about has exercised my mind a good deal. Several points arose for consideration.

The isolated position the mental hospitals undoubtedly occupy in the social organization is the outcome of the endeavour, actuated by motives of public decency and regard for the feelings of patients and their friends and relatives, to avoid pandering to idle curiosity and morbidity, and to secure rest and seclusion for the patients.

There is no doubt that indiscriminate visiting of the wards by the public could not be allowed. Such would appeal too much to the morbidly inclined, though it is true that they would find little to satisfy them anywhere in a mental hospital. Neither would it be fair to the patient or his relatives and friends that his loss of control and distressed state of mind should be freely open to prying eyes of neighbours prone to uncharitableness. Mental hospitals harbour no secrets except the identity of the patients and their individual sayings and doings.

To say that the insane are treated "behind a shut door" is not quite the truth, and is thus very misleading. The visiting-rooms and a good number of wards of the mental hospitals as a rule swarm with visitors twice weekly and on public holidays. Anybody who gives the name of a patient can gain admission on visiting-days. All patients seriously ill can be seen at any time of the day or night. But visitors are to individual patients—not to the hospital generally. It is rare that the medical officer has occasion to forbid a visit. Thus the mental hospital always has strangers within its gates.

There must be at least 20,000 people actually employed in mental hospitals. Each employee belongs to some family circle or other, and so, through them alone, to many thousands of people scattered throughout the land the happenings in mental hospitals can be no secret. About 10,000 patients pass through the mental hospitals annually—in 10 years 100,000. These also, in the main, have relatives and friends. Under these conditions it would be difficult to keep anything secret in a mental hospital except personal details like the names of patients, etc.

So "behind a shut door" is not really truly descriptive of mental hospitals. It is rather one of those sayings dear to the hearts of smart journalists and other purveyors of sensationalism.

Now all these facts regarding the mentally afflicted and the work of the public mental hospitals should be laid to heart by all social workers, who can do much to educate public opinion and help to remove that ignorance and prejudice which militates against progress being made in regard to the care and treatment of the mentally afflicted.

*What, therefore, is the solution of the problem of the isolation of the mental hospitals and the insane, and the disabilities to both patients and staff which arise therefrom?*

I concluded some five years ago that the way out of the difficulty would be to bring the outside community to bear upon the daily life of the mental hospitals in the form of hospital visitors and social workers—level-headed, discreet and kindly women, and in some cases men, with some idea of mental disorders, who would bring into the wards regularly a breath of fresh air from the outside world to combat institution conventionality and narrow-mindedness. These social workers, failing others, would pay particular attention to friendless patients. They would act as a communicating link between the patients and their homes. They would gather reliable information regarding the patients' home environment of great value to the medical officer, and thus help him materially as regards causation, treatment, and subsequent disposal of the patients on recovery. They would interest themselves in the social life of the wards, the entertainment and recreation of the patients, and be a consolation and comfort especially to those confined to bed for physical reasons. Above all, it would be a way in which the public could be brought into closer touch with the mental hospitals. To such social workers when they spoke—say in annual conference—the public would listen and have confidence in what they said.

And so it came to pass that, with the approval of the London County Council Mental Hospitals Committee, a beginning was made at Horton Mental Hospital by the appointment on June 9, 1922, of Miss V. M. Dale as Hospital Visitor, and before I conclude my address I will tell you something of her work.

There are now hospital visitors to six out of the nine London County Mental Hospitals, and the three hospitals unprovided only await suitable ladies coming forward to take up these duties.\*

The movement has spread to the provincial mental hospitals, where it is making good headway, and I hope that in due course no medical administration of any public mental hospital will be considered complete without its hospital visitor, assisted by a sufficient number of social workers for service in the wards and in the homes of the patients.

I can speak of the value of the hospital visitor's work from first-hand knowledge at Horton Mental Hospital. There she has been a source of great comfort to the patients and, as the intermedium between them and their homes has solved many difficulties in not a few cases. She has assisted in organizing parties in the hospital and picnics to pretty spots in the neighbourhood, etc., and in many ways added to the patients' happiness. Her visits to the patients' homes have never been resented: on the contrary, they have been much appreciated. The nurses welcome her visits, and value her help in providing for the patients' contentment and doing many little services for them which nobody else is in a position to do. The staff at Horton would not like to lose the Hospital Visitor. There was never

\* The author takes this opportunity of expressing his appreciation of the valuable assistance given in this provision by the Society of the Crown of Our Lord which now maintains a whole-time visitor at one of these hospitals. Miss Dale is the head of the Society's Hostel.

any difficulty in finding the directions in which she could be of most service ; her position has been consolidated, and the part she plays is now an integral part of the medical administration.

It should be noted that she does not, as a rule, undertake " after-care " work. This is done by the workers of the After-Care Association, and it is very advisable that it should continue so, as it is a job for which special training and knowledge is required.

After-care is best centralized in an organization which can direct the operations throughout the land and keep in touch with employers over a wide area, and also maintain convalescent institutions, rest-houses or hostels, which are absolutely necessary in dealing with cases not quite fit to be given entire freedom. Such a central association can follow up cases however widely they scatter on complete discharge. Local branches or after-care societies can materially aid the parent association in this work.

The New York State hospitals for the insane and the mental hospitals of many of the other American states have very complete organizations for carrying out the work I have just been describing, and its importance is very thoroughly recognized. The officials appointed to do this work are trained psychiatric social workers, and they are regular officers on the staff of the hospitals.

In America happier relationships exist between the public on the one hand and the mental hospitals and their staff and patients on the other, and there is but little of that regrettable element of superstition, suspicion and mistrust which unfortunately largely characterize such relationships here.

In this country I think it will be essential for some years that our hospital visitors should not be paid officials of any particular hospital or mental service. Once they become officials, their work, like that of all mental hospital employees, will be looked upon with suspicion and their influence weakened accordingly. To be strong and to have the respect and influence they should have, they must be independent but such arguments cannot be advanced against their receiving out-of-pocket expenses.

I dream of the time when perhaps the mental hospital visitors will found an organization of their own and become a power in the land, to which both the public and the mental hospital authorities and their servants can look for help and counsel as being specially qualified to envisage difficult social psychiatric problems from both points of view. Some such body of opinion is badly needed at times.

It is necessary to say something more regarding the field work of the hospital visitors.

Dr. R. H. Cole, in his Presidential Address, Section of Psychiatry, Royal Society of Medicine, in quoting the statistics of the Board of Control in regard to the recoveries and total discharges of direct admissions of certified patients, and the recovery rate at an American psychopathic hospital, says, " Such figures would no doubt compare favourably with the same number of patients admitted to a general hospital." I have no grounds for disputing this statement, though if I had my choice as to whether I would be afflicted with a physical or a mental complaint,

from the point of view of the chances of recovery, I should select a physical one, and I fancy he would too.

He does not, however, mention the really important point, though it doubtless occurred to him, and that is the future of the 50-70% who do not recover. As regards general hospitals, they either die or return to outside life and do not remain very largely a charge on the public.

The public not only expect mental patients to recover, but they object to the accumulation at their charge of the chronic insane—so much so that from time to time a really certain cure, the lethal chamber, finds its advocates.

Thus the public expect better results from the mental hospitals than they do from the general hospitals. They have in reality no justifiable complaint on this comparison as to the proportion of cases returned to their homes, either cured or alleviated, but there is something to be said for their objection to maintaining those who are not or cannot be cured.

So the psychiatrist has a hard task before him if he is to satisfy all the requirements of the public and he cannot afford to lose a single curable case.

Now for some years before the war, and especially since, it has begun to dawn on him that he has been expending too much time and energy in painting pictures of mental disorders—clinical pictures, anatomical pictures, chemical pictures—all very descriptive of the diseases he is dealing with, but far from being satisfactory as guides to their successful treatment—which of course is his real aim and object.

Up to that time psychology largely limited itself to answering the question "How?" of life and behaviour, and found itself at a full stop when the question "Why?" was put. It was still at the descriptive stage and had not yet passed into the dynamic stage of a science.

Since then, however, dynamic conceptions in psychology have made their advent and have been exerting a powerful influence on psychiatry to this day.

Psychiatrists slowly but surely came to realize that the answer to the question "Why?" of all the pictures they had been painting hitherto was the all-important factor in the treatment of mental disorders. Now, these dynamic conceptions in psychology and psychiatry are based upon biological and genetic data of two kinds—racial and individual. The former have to do with innate dispositions or instincts and their racial evolution purpose, and the latter with the individual's strivings or conation in relation thereto and their subservience to the social instinct and the conflicts that follow.

Thus it has come about that the clinical psychiatrist is tending less and less to view his cases from the descriptive and static point of view of reason, judgment, belief, ideas, sensation, hallucination, association, incoherence, retardation, amnesia, etc., in favour of the more dynamic conceptions of instincts, motives, wishes, desires, moods, emotions and, above all, character—which embraces natural intelligence, disposition, temperament, sentiment. He is not satisfied with descriptions, but wants to know "Why?" and searches the patient's mind from its infancy for this purpose. He goes further and invades that psychic underworld—the phylogenic mental past—in which are to be found those stores or springs of energy which lie at the roots of all human behaviour. Speaking figuratively, he is no longer satisfied with



naked-eye appearances, which do not help him very much, but seeks with the aid of the microscopes those facts which are essential to the proper understanding of his cases.

Bergson says : " Doubtless we think with only a small part of our past, but it is with our entire past, including the original bent of our soul, that we desire, will, and act."

Now the building up of a case of mental disorder must commence from this dynamic view-point if treatment is to be direct and effective. Mental symptoms, anatomical and chemical physical pictures, though very necessary, merely reflect deeper psycho-biological disturbances which can only be arrived at by a close examination of the history of the patients in its three main directions, namely (*a*) family history, (*b*) personal history, commencing from childhood, (*c*) history of the present illness. Without these treatment can only be empirical, or limited to that designed to meet the physical accompaniments of mental disorder.

But to obtain these very vital historical facts, merely interviewing the patient and his friends at the hospital is not sufficient, and the information thus obtained is often unreliable and sometimes purposely misleading. Insanity in the family, directly exciting causes and even previous attacks are not uncommonly concealed, for the not altogether inexcusable reason that thereby such information might add to the length of the patient's detention.

The chief fact concealed is the relative's own participation in the cause. For example, the attitude of the husband, whose treatment of his wife may be all important. Naturally his account is designed to attribute blame to anybody or anything but his own personal actions. The same of parents and children and *vice-versâ*. The ascertainment of the circumstances which lead to the patient's admission is also important.

Furthermore, the information so obtained is incomplete inasmuch as first-hand knowledge of the patient's previous environment cannot be ascertained.

There can be no question that the information gleaned by the medical officer in the usual way should always be checked, verified and supplemented by visitation of the homes and prior surroundings of the patient, to arrive at the influences to which he has been exposed as far back in his life as is practicable, to ascertain his habits, his family life, his character, his temperament, his relationships with employer, friends, neighbours, etc.—in other words, to find out what manner of man he really is, how the world has treated him, and what he has hitherto done with his life, etc.; also to relieve the anxiety of friends and relations and to assure them that the patient is in good hands.

Let me put it another way : The psychiatrist cannot now content himself with pictures, however well drawn and coloured, of the damage done, and with hearsay evidence as to its occurrence, but must proceed to the place (by deputy), where the accident happened, and hold an enquiry on the spot and thus obtain first hand the evidence of eye-witnesses.

Now experience shows that a discreet, discerning and sympathetic visitor or social worker is needed for this work, which obviously cannot be undertaken by the medical officer in person. Even if he could be spared from the hospital,

he would often fail in his purpose, while success as a rule rewards the efforts of the visitor or social worker.

Too much emphasis cannot be laid on the fact that this information must be forthcoming before effective treatment can be commenced. It is not a question of inquiries for compiling statistics or for educational purposes or for ascertaining mental deficiency, but of the life or death of the mind, without which man is but clay. So the hospital visitor and the social workers generally of a mental hospital do really vital work, and upon their zeal, efficiency and loyalty in large measure depends the best that modern psychiatry can do for the cure of mental disorders.

#### APPENDICES.

In the spring of 1922 I heard that Colonel Lord was enquiring for someone to visit the patients at Horton, not as an L.C.C. official, but as an authorized hospital "Visitor" from the outside world, and I most gladly undertook to try and do this work. At first it was rather tentative, but soon I found that it developed in the following three directions:

1. Visiting the patients in the hospital.
2. Doing commissions for the patients.
3. Visiting the patients' homes and friends on behalf of the doctor.

1. *As regards the first.* I have been down to the hospital pretty regularly two or three times a week ever since 1922. I began by visiting chiefly the admission villa hospitals and getting to know the patients as they came in. It is often to these newly admitted patients that one can be of most use and, if their stay in hospital is prolonged, they usually are passed on to the main building, where I can follow them up; so that by now I have friends in pretty well all the wards.

A great many of the patients are quite coherent and clear in their minds on most subjects, and they welcome a chat and the sight of someone from outside the hospital; and as regards the more difficult people, I have found that however confused they are, and apparently unconscious of their surroundings and of one's presence, they are often not *really* unconscious of it, and some have told me afterwards that, my just sitting down beside their beds, has made them feel that they had a particular friend in the hospital, and that has given them comfort and relief.

Besides actually visiting the wards, I am also often allowed to take patients for walks into Epsom, where they love to see the shops and have some tea, or else ten or twelve of them come (with one or two nurses) for a picnic up on the Downs or Box Hill, where we spend the afternoon.

2. *Doing jobs for the patients* is also part of my work. They often ask me to go and see their friends, who cannot visit them just at first, and the effort of writing a letter to whom is often too much for them. It is an interesting fact, I think, that they never give me an incorrect address. Even after a silence of forty years I was able to get a reply from a long-lost brother in Canada for one old patient. The brother's letter began: "Forty years ago I wrote to you, and you never answered my letter." He had not tried again! Sometimes by visiting the home one can reassure the patient on certain points. One young mother who had just had twins had the delusion that they and her house had been burnt. I went to Camberwell and saw the twins safely tucked up in bed and the house still standing. I suppose the delusion must have been weakening, for the patient really believed me when I told her and her mind was easier in consequence, though she said afterwards that she was not *quite* sure that I was not "pulling her leg."

3. *As regards visiting the patients' homes on behalf of the doctor.* I will only speak

of this from the point of view of the visitor, and from that point of view I think it is almost the most interesting part of the work. It certainly involves a great deal of journeying about London, but, apart from any value that the information obtained may or may not have for the doctor, one is amply repaid by the real gratitude of the relations in nearly every case. It is often a very real relief to them to talk freely about the patient and his misfortune to someone with some sort of understanding of it, after having kept silence as much as possible till then. Also they do welcome news of a loved mother or wife or child during the first few weeks, when they cannot themselves visit the hospital, and I can tell them not only how the patient is, but also how well they are being cared for and how beautiful is the hospital and its grounds, and thus relieve their anxieties and correct many misconceptions, only too common, as to mental hospitals and the conditions under which the patients live.

V. M. DALE.

## II.

Since this address was written, the Report of the Royal Commission on Lunacy and Mental Disorders (England and Wales) dated July 7, 1926, has been made available. It very amply endorses the views set forth by the author on many matters, especially by the following recommendations:

"IV (b). Voluntary Boarders might be received in any public mental hospital, registered hospital, licensed house, general hospital, nursing home or in single care."

"XIX. We recommend for general adoption the practice initiated in certain mental hospitals of the London County Council by which voluntary unofficial visitors of suitable experience have been appointed to act as friends of the patients and the relations while patients are under care."

### *Summary and Conclusions.*

1. The "group mind" defined and described, and then compared in respect of ancient, medieval and modern times, especially in its attitude to mental disorders and those mentally afflicted.

2. Arguments in support of the proposition that the public attitude to the latter is in a measure atavistic and regressive and still strongly tainted with medievalism.

3. Why does the public view mental hospitals differently from general hospitals? An answer is attempted: Historical research in regard to both kinds of hospitals—origin the same. History of the treatment of mental disorders in ancient and medieval times sketched. Lecky and the first hospital or infirmary supported by public subscriptions. Reasons for supposing that the public hospital system received its greatest impetus from the establishment of the hospitals of the Order of Knight Hospitallers. The word "asylum" defined and the history of its use given. Its use as regards the insane not so proper in these days as "hospital." The word "hospital" defined and the history of its use given. History of the voluntary general hospital system in England from the 11th century. More detailed and critical history: The history of a failure to found an adequate voluntary mental hospital system from 1750 onwards and why—again the group mind still infected

with medieval thought a cause. The renaissance of psychiatry in Europe. Pioneer work of John Howard and Lord Shaftesbury and the late 18th and early 19th century psychiatrists. Estrangement of mental and general hospitals never so marked in Scotland. This estrangement regarded as a calamity and to have retarded progress in psychiatry.

4. Future prospects: Importance of the admission of voluntary patients to all mental institutions; of affiliation and reciprocity between mental and general hospitals; of mental clinics; and of a closer practical union between psychiatry and general medicine.

5. What the public ought to know about the mind and mental disorders and how it can be best disseminated.

6. What the public ought to know about mental hospitals and how it can be best disseminated.

7. Author's views regarding (5) and (6) adopted and how disseminated by the largest local lunacy authority in the Empire among relatives and friends of mental patients.

8. The attitude of the Press to mental disorders and mental institutions criticized as retarding enlightenment and progress.

9. Isolation of mental institutions deplored. The causes of it and its effects.

10. What mental hospitals need: Mental hospitals not entirely "closed" institutions and why they can never be entirely "open" institutions.

11. Solution of the isolated position of mental hospitals to be found in the appointment of independent, unofficial, and voluntary hospital visitors as an intermediary between patients and their homes. Author describes how he originated this movement in 1921, its adoption by the London County Council and other local lunacy authorities, and recently recommended for general adoption by the Royal Commission on Lunacy, etc.

12. Psychiatric field work and workers. The dynamic approach to treatment the only sound and successful one. The necessity for environmental investigation in regard to mental disorders and history-taking.

13. Report of a hospital visitor and psychiatric field worker.

14. Author's views generally and in some instances specifically confirmed by the findings of the Royal Commission on Lunacy, etc.

